

**RESIDENT / HUMANITARIAN COORDINATOR  
REPORT ON THE USE OF CERF FUNDS  
ANGOLA  
RAPID RESPONSE  
YELLOW FEVER 2016**

**RESIDENT/HUMANITARIAN COORDINATOR**

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## REPORTING PROCESS AND CONSULTATION SUMMARY

- a. Please indicate when the After Action Review (AAR) was conducted and who participated.

*Review agreed on 02/09/2016 and 07/09/2016.*

- b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES  NO

- c. Was the final version of the RC/HC Report shared for review with in-country stakeholders as recommended in the guidelines (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?

YES  NO

Final version shared with UNICEF and UNDP, although this initiative was mainly implemented by WHO

## I. HUMANITARIAN CONTEXT

| TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US\$)          |   |                   |
|--|---|-------------------|
| Total amount required for the humanitarian response:   |   |                   |
| Breakdown of total response funding received by source | Source                                  | Amount            |
|  | CERF                                    | 3,000,000         |
|  | COUNTRY-BASED POOL FUND (if applicable) | 4,508,559         |
|  | OTHER (bilateral/multilateral)          |                   |
|  | <b>TOTAL</b>                            | <b>10,473,618</b> |

\*The total amount does not match because this was considered an underfunded emergency.

| TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US\$)   |               |                |                  |
|--|---------------|----------------|------------------|
| Allocation 1 – date of official submission: 06/04/2016- 05/10/2016 |               |                |                  |
| Agency   | Project code  | Cluster/Sector | Amount           |
| WHO  | 16-RR-WHO-017 | Health         | 3,000,000        |
| <b>TOTAL</b>   |               |                | <b>3,000,000</b> |

| TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US\$) |                  |
|--|------------------|
| Type of implementation modality  | Amount           |
| Direct UN agencies/IOM implementation*                                     | 3,000,000        |
| Funds forwarded to NGOs and Red Cross / Red Crescent for implementation    |                  |
| Funds forwarded to government partners                                     |                  |
| <b>TOTAL</b>   | <b>3,000,000</b> |

\* To be implemented by **ICG (International Coordination Group)**: An international mechanism integrated by the UN Agencies such as WHO and UNICEF together with MSF and International Red Cross that apply the agreed strategy and mechanism for the release and use of yellow fever vaccine.

## **HUMANITARIAN NEEDS**

The Ministry of Health notified WHO on an urban yellow fever outbreak in Luanda on the 21st of January 2016 with the first cases being identified in Viana District on the 5th of December 2015. The yellow fever outbreak in Angola has seen significant increases in the number of reported cases and high case fatality rates (defined as deaths among suspected cases/confirmed cases). The outbreak was originated within members of the Eritrean refugee population and has spread rapidly to other inhabitants. As of the 28th of February, there have been 634 suspected cases reported as well as 110 deaths in Angola. There have been a growing number of additional districts in Luanda who are reporting cases and with high vector density. The reported suspected cases have now also extended to other districts in Luanda as Belas, Samba, Cacuaco, and Cazenga; as well as other districts in the provinces of Huambo, Huila and Uige. As the number of suspected cases is being confirmed in cities like Luanda, which has a strong demographic relationship with neighbouring countries, the risk of spread to other areas in the region and worldwide was clearly increased. WHO analysed the situation and took into account the grading criteria of scale, urgency, complexity and context. On the basis of this analysis, it has been proposed to the WHO Director General to declare this YF outbreak in Angola as an internal WHO Grade 2 emergency.

The total population of Luanda was at risk for yellow fever, which equals 6,626,200 people. Only children under 6 months of age are not at risk as they are covered by maternal antibodies. The Routine Expanded Program Immunization EPI immunization exists in Angola since 1997, but a low vaccine coverage is reported (around 61%) in Luanda so the cohort protected is uncertain, taking in account the high migration to Luanda from other underserved population by routine vaccination. All age groups were at risk and the virus is not being gender bound.

The scale of the outbreak increased exponentially with not only Luanda being affected (which has high vector density thus increasing the risk of amplification) but also other provinces. The outbreak extended outward to other provinces leaving national capacities stretched and in need of international assistance, particularly with epidemiological investigation, laboratory diagnostics, coordination, training, clinical management and logistics. The spread of yellow fever as well as the suspected cases had the potential to impact trade as the spread impacts travel in and out of the country due to the high yellow fever virus circulation. Angola suffers from low rates of immunization for yellow fever, leaving much of the population vulnerable to the current outbreak. The last mass vaccination campaign was conducted in 1988. Mass population mobility took place during and after the war which affects the coverage of the 1988 campaign.

At the time the CERF funds were requested, there was a heightened sense of urgency to respond to the yellow fever outbreak due to the high CFR rate (22.6%) and the spread to the various provinces in such a short period. The urgency was also there due to the low national capacity and delayed actions of the government. Therefore, the role played by mass media, social and community organizations has been fundamental to achieve the goals. Even though in former campaigns in past years (Polio and tetanus neonatal), efforts have been done to diffuse through mass media and civil society, Information on Health, vaccination, hygiene and basic sanitation are still low in the general population, families and Health staff. Also the level of social and community participation of civil organization must be reinforced and motivated in a permanent basis, because their knowledge is very low and low morale sets in very rapidly, as they cannot see immediate gratification.

In order to accelerate response with international support, a clear coordinated response and monitoring of the expansion of the outbreak was needed, which included mass vaccination campaigns. To realize this campaign, it was necessary a joint communication and social mobilization effort directed to the general population about the benefits of the vaccine, the sanitary measures to control the vector and basic sanitation measures. As well as a continued advocacy effort with political, community and religious leaders motivating them to actively participate in the campaign and reinforce inter-person communication and the mobilization of civil society and communities.

Angola is considered to be a middle yellow fever endemic country, with not reported cases of yellow fever since 1988 (last 28 years). What made this outbreak more complex is that no national risk assessments were conducted which would have allowed for areas at risk to be prioritized and it would have established preventative measure through preventive mass campaigns or good routine EPI for children. There is a case-base surveillance systems established at the national level, however it is not really efficient as well as the national laboratory which is not performant. Country level support was thus important at looking at outbreak management and coordination. This country level support was organized jointly by the WHO AFRO and HQ.

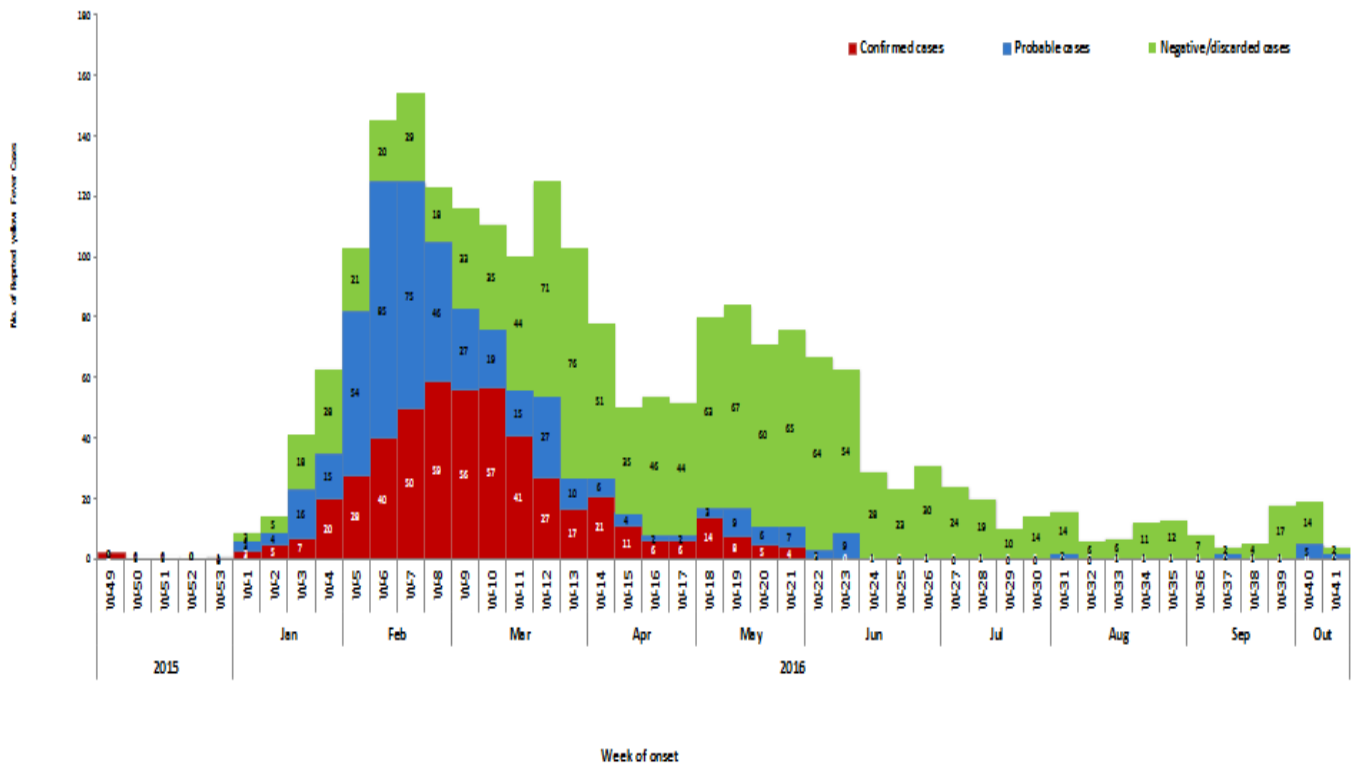
Angola is not eligible for support from the Global Alliance Vaccination Initiative (GAVI) thus doesn't benefit from the usual support provided by other Yellow Fever endemic countries. The Angolan government can only support 50% of the bundles vaccine costs and cannot support the needed operational costs associated with the mass vaccination campaign.

Capacity is a big issue in the country when it comes to the organization and providing of a rapid response. It was identified as a real need for international involvement particularly from the public health agencies. The World Health Organization enhanced its technical leadership during the outbreak, as well as the UNICEF its experience in communication and social mobilization of the population in health campaigns.

## II. FOCUS AREAS AND PRIORITIZATION

This application focuses on the replenishment of the yellow fever emergency stockpile at 32% of total amount of vaccines supplied to attend the emergency due to the outbreak of yellow fever in Angola. This outbreak implied a high risk of spread.

Fig.1. Yellow Fever Suspected and Confirmed Cases -Luanda  
5 Dec 2015— 20 Oct 2016



### III. CERF PROCESS

There is a further constraint that complicates the response to the yellow fever outbreak. Due to the urgency to vaccinate and contain the outbreak as quickly as possible, the yellow fever International Coordinating Group (ICG) shipped 6.4 Million vaccine doses from their emergency stockpile which were shipped for free to GAVI eligible countries. However since Angola is not a GAVI eligible country, the country has to cover the cost for replenishment of the yellow fever emergency stockpile. There is also a global shortage of the yellow fever vaccine. If the number of suspected cases increase over the 6 million threshold than there will be a lack of available vaccines worldwide. It is hence of utmost urgency to replenish the ICG emergency stockpile for yellow fever. The CERF rapid response window was chosen as the quickest mechanism to achieve that goal.

### IV. CERF RESULTS AND ADDED VALUE

| TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR <sup>1</sup> |              |              |           |             |            |           |                 |               |           |
|---|--------------|--------------|-----------|-------------|------------|-----------|-----------------|---------------|-----------|
| Total number of individuals affected by the crisis:                                   |              |              |           |             |            |           |                 |               |           |
| Cluster/Sector  | Female       |              |           | Male        |            |           | Total           |               |           |
|   | Girls (< 18) | Women (≥ 18) | Total     | Boys (< 18) | Men (≥ 18) | Total     | Children (< 18) | Adults (≥ 18) | Total     |
| Health  | 577,024      | 524,962      | 1,101,986 | 549,413     | 455,650    | 1,005,063 | 1,126,437       | 980,612       | 2,107,049 |

<sup>1</sup> Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector

#### BENEFICIARY ESTIMATION

With the 3 million dollar support an estimated 2,107,049 high risk population will be vaccinated including those living in a high transmission area. The effect of protection is even higher as 80% of vaccine coverage will protect the whole population.

| TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING <sup>2</sup> |                 |               |           |
|---|-----------------|---------------|-----------|
|   | Children (< 18) | Adults (≥ 18) | Total     |
| Female  | 577,024         | 524,962       | 1,101,986 |
| Male  | 549,413         | 455,650       | 1,005,063 |
| Total individuals (Female and male)   | 1,126,437       | 980,612       | 2,107,049 |

<sup>2</sup> Best estimate of the total number of individuals (girls, women, boys, and men) directly supported through CERF funding This should, as best possible, exclude significant overlaps and double counting between the sectors.

\*On the total number of beneficiaries and number of vaccines requested, there is a wastage percentage (unavoidable loss of vaccines for operational reasons) so the people to vaccinate is not equal to the vaccines utilized (a wastage rate of around 11%)

\*Table 4 and 5 match since there is only a sector/cluster involved in this CERF funding: Health.

## **CERF RESULTS**

The CERF results provide the chance to quick deliver the vaccines in the very beginning of the outbreak. Despite an initial low performance, results improved and high vaccination coverage was achieved.

### **CERF's ADDED VALUE**

**a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?**

YES  PARTIALLY  NO

The requested funds allowed to release the vaccines to initiate the vaccination in early February and later replenish the world emergency stockpile. As evaluated today (see graphic), this intervention was crucial in the trend of the outbreak.

**b) Did CERF funds help respond to time critical needs<sup>1</sup>?**

YES  PARTIALLY  NO

Without the support of the current CERF the replenishment of the worldwide would not be possible in special as Angola did not apply to GAVI funds due to their middle income grading process. With the vaccines provided in early February 2016 was possible to modify the trend of the outbreak in Luanda and together with complementary activities in the provinces to finally control de outbreak and reduce the exportation to other areas of the country as well other countries notably Democratic Republic of Congo.

**c) Did CERF funds help improve resource mobilization from other sources?**

YES  PARTIALLY  NO

The availability for funds for vaccine and related expenses in vaccine material and shipment costs provide enough time to fundraising from other sources to operational costs mainly including those from Angola Government released in March.

**d) Did CERF improve coordination amongst the humanitarian community?**

YES  PARTIALLY  NO

In this outbreak was initiated the strategy of an ad-hoc Incident Manager System to operate the Outbreak Response. The CERF application process initially involved the UNICEF and UNDP participation and strengthened the coordination mechanism among them. Another important effect was the improvement in the relationship between the country mechanism and the ICG (including key actors as MSF and International Red Cross) as well as with the Yellow Fever Team at HQ. This initial support increased the agreement for identify more sources for fundraising

**e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response**

This CERF implied the early participation of HQ level of the United Nations Agencies. A closer participation and coordination was a surplus added value.

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<sup>1</sup> Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns, locust control, etc.).

## V. LESSONS LEARNED

| <b>TABLE 6: OBSERVATIONS FOR THE <u>CERF SECRETARIAT</u></b>   |   |  |
|--|---|--|
| <b>Lessons learned</b>   | <b>Suggestion for follow-up/improvement</b>   | <b>Responsible entity</b>                  |
| This type of CERF application with a specific use through a prearranged and unique mechanism (ICG) probably need a simplest mechanism  | The HQ components of the UN Agencies would conduct the process as it in reality is addressed to replenish a central stockpile   | OCHA, ICG and HQ of UN Agencies            |
| There was an important gap for operational cost in early February that delays the implementation of the reactive campaign.   | Include a basic funding to initiate early the reactive vaccination campaign together with the expenses. As the case of the vaccine stockpile the initial operational cost would have a character of a “refillable” component                            | Yellow Fever Partnership, ICG, OCHA        |
| There was an early interest of the Angola Government to acquire the total vaccine stock to vaccinate the whole country. However, there is still a large gap worldwide on Yellow Fever vaccine production. Even when the Yellow Fever vaccine is a very effective and safe vaccine it is regrettable that it is not possible globally to increase its production and avoid situations as occurred with this outbreak. | The increase in the global production of Yellow Fever would be a priority to guarantee an increased worldwide vaccine stockpile and decrease the risk of spread the disease. A global agreement about that is a high priority advocacy at central level | Yellow Fever Partnership, ICG, UN Agencies |

| <b>TABLE 7: OBSERVATIONS FOR <u>COUNTRY TEAMS</u></b>   |   |   |
|---|---|---|
| <b>Lessons learned</b>  | <b>Suggestion for follow-up/improvement</b>   | <b>Responsible entity</b>   |
| The new Incident Management System needs to include a fundraising inter-agency mechanism to provide a synergistic support to the early intervention period  | Under the Resident Coordination propose a fundraising component in the contingency plan in epidemic prone diseases that have an intervention with a high effective and safe vaccine as in the Yellow Fever outbreak     | UN-RC, WHO, UNICEF, UNDP  |
| As in the case of the lack of coverage of support by GAVI to pay the vaccines in the case of Angola (an oncoming country to be considered a medium income country) is necessary to identify for local alternative mechanisms to support the contingencies with disaster/emergency events that need vaccines | With the oncoming process of grading to a medium income country it is necessary to identify all the necessary alternative mechanisms to decrease the contingencies as those related to disasters and health emergencies | UN-RC, National Civil Protection Committee, MOH, WHO, UNICEF UNDP |



## VI. PROJECT RESULTS

| TABLE 8: PROJECT RESULTS   |  |                  |   |   |                  |                  |
|--|--|------------------|---|---|------------------|------------------|
| CERF project information   |  |                  |   |   |                  |                  |
| 1. Agency:   | WHO  |                  | 5. CERF grant period:                             | 06/04/2016- 05/10/2016                        |                  |                  |
| 2. CERF project code:  | 16-RR-WHO-017  |                  | 6. Status of CERF grant:                          | <input type="checkbox"/> Ongoing              |                  |                  |
| 3. Cluster/Sector:   | Health   |                  |   | <input checked="" type="checkbox"/> Concluded |                  |                  |
| 4. Project title:  | Complete and accelerate the yellow fever vaccination campaign for the population in the province of Luanda |                  |   |   |                  |                  |
| 7. Funding   | a. Total funding requirements <sup>2</sup> :   | US\$ 10,473,618  | d. CERF funds forwarded to implementing partners: |   |                  |                  |
|  | b. Total funding received <sup>3</sup> :   | US\$ 10,354,723  | ▪ NGO partners and Red Cross/Crescent:            |   |                  |                  |
|  | c. Amount received from CERF:  | US\$ 3,000,000   | ▪ Government Partners:                            |   |                  |                  |
| Beneficiaries  |  |                  |   |   |                  |                  |
| 8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) <u>directly</u> through CERF funding (provide a breakdown by sex and age). |  |                  |   |   |                  |                  |
| Direct Beneficiaries   | Planned  |                  |   | Reached                                       |                  |                  |
|  | Female   | Male             | Total   | Female  | Male             | Total            |
| Children (< 18)  | 643,266  | 683,121          | 1,326,387   | 627,192                                       | 666,050          | 1,293,242        |
| Adults (≥ 18)  | 458,720  | 321,942          | 780,662   | 447,257                                       | 313,897          | 761,154          |
| <b>Total</b>   | <b>1,101,986</b>   | <b>1,005,063</b> | <b>2,107,049</b>                                  | <b>1,074,449</b>                              | <b>979,947</b>   | <b>2,054,396</b> |
| 8b. Beneficiary Profile  |  |                  |   |   |                  |                  |
| Category   | Number of people (Planned)   |                  | Number of people (Reached)                        |   |                  |                  |
| Refugees   |  |                  |   |   |                  |                  |
| IDPs   |  |                  |   |   |                  |                  |
| Host population  |  |                  | 2,107,049   |   | 2,054,396        |                  |
| Other affected people  |  |                  |   |   |                  |                  |
| <b>Total (same as in 8a)</b>   |  |                  | <b>2,107,049</b>                                  |   | <b>2,054,396</b> |                  |

<sup>2</sup> This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

<sup>3</sup> This should include both funding received from CERF and from other donors.

|  |  |
|--|--|
| <i>In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:</i> |  |
|--|--|

\* As a clarification on number of vaccines requested vs. target population: the requested vaccines were 2.255.100; population planned for vaccination 2,107,049 and – population vaccinated 2,054,396.

| <b>CERF Result Framework</b> |  |  |  |
|------------------------------|--|--|--|
| <b>9. Project objective</b>  | To support the yellow fever vaccination in Luanda Province with an estimated population of 6,626,200 persons in order to prevent the further spread of yellow fever.                         |  |  |
| <b>10. Outcome statement</b> | The ICG emergency yellow fever stockpile has been replenished, and the risk of the national and international spread of the yellow fever outbreak in the Luanda Province has been minimized. |  |  |
| <b>11. Outputs</b>           |  |  |  |
| <b>Output 1</b>              | 2,338,828 doses of yellow fever vaccines have been replenished to the ICG emergency stockpile with which 2,107,049 individuals have been vaccinated in the Luanda Province.                  |  |  |
| <b>Output 1 Indicators</b>   | <b>Description</b>   | <b>Target</b>  | <b>Reached</b>   |
| Indicator 1.1                | Number of doses replenished to the ICG emergency stockpile   | 2,338,828  | 2,338,828  |
| Indicator 1.2                | Percentage of Luanda province population above 5 months of age, vaccinated against yellow fever  | 80%  | 93%  |
| <b>Output 1 Activities</b>   | <b>Description</b>   | <b>Implemented by (Planned)</b>                              | <b>Implemented by (Actual)</b>                               |
| Activity 1.1                 | Reimburse the OCG and replenish the yellow fever emergency stockpile to 32%  | WHO  | WHO  |
| Activity 1.2                 | Vaccinate at least 2,107,049 individuals in Luanda province  | Districts Health Direction, WHO, UNICEF, MSF, Red Cross, CDC | Districts Health Direction, WHO, UNICEF, MSF, Red Cross, CDC |

|   |   |
|---|---|
| <b>12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:</b>  |   |
| The purchased vaccine stock was crucial to contribute to stop transmission at the city with the largest population in the country. Despite it was received after a big proportion of Luanda population was vaccinated, the central area of the city (so-called district of Luanda) was vaccinated with this support. In other side the vaccine the important provinces of Huambo, Benguela and Cuanza Sul jeopardized by the spread of the outbreak from Luanda received vaccines to implement vaccination in their main districts (seat and more populated ones).        |   |
| <b>13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:</b>  |   |
| As this CERF application mainly encompasses actions coordinated and developed at central level the component of accountability relies more at this level and is more related to verify if the current accountability of these organization works properly   |   |
| <b>14. Evaluation: Has this project been evaluated or is an evaluation pending?</b>   | EVALUATION CARRIED OUT <input type="checkbox"/>           |
| The evaluation was not planned as this project was directed to the purchase of the vaccines and has not operational components nor implementation by a third party. The purchase process and all the components of the delivery of the vaccines was performed by the only authorized Committee for this purpose (ICG)<br><br>The evaluation of the entire outbreak is not yet available as the government has not accepted yet to declare the end of the epidemic. The vaccination implemented early in February modified decisively the trend and scope of the epidemic. | EVALUATION PENDING <input type="checkbox"/>               |
|   | NO EVALUATION PLANNED <input checked="" type="checkbox"/> |

## ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

|        |  |
|--------|--|
| GAVI   | Global Alliance for Vaccines and Immunisation              |
| ICG    | International Coordination Group for yellow fever vaccines |
| UNICEF | United Nations Children's Fund                             |
| WB     | World Bank   |
| WHO    | World Health Organization                                  |